doctor's professional judgment in assessing his patient's needs is at stake here, and the ruling does not in any way mean a relaxation in the bonds of confidence that exist between doctor and patient.

[1] *British Medical Journal*, 1970, **4**, 127.
[2] Herzberg, B. N., Johnson, A. L., and Brown, S., *British Medical Journal*, 1970, **4**, 142.
[3] *British Medical Journal*, 1970, **2**, 378.
[4] Weir, R. J., *et al.*, *Lancet*, 1971, **1**, 467.
[5] *Members Handbook*, London, British Medical Association, 1970.

Treatment of Habitual Drunken Offenders

The report of the Home Office working party on habitual drunken offenders[1] is a major review of a much neglected social problem. Though chary of proposing a solution, the working party has come up with a set of proposals which, if carried out, would do much to make society's response to the man or woman drunk in the street more humane and more rational. For the continuance of the present revolving door system, which pushes the drunk repeatedly and aimlessly through court and prison, the report could find no one in favour—policemen, magistrates, prison officers, and social workers all shared the unanimous view that the present system is a degrading, expensive, and ineffectual absurdity.

The report does not envisage any one new type of treatment as holding the magic answer, but insists rather that the task is to design a system of integrated care by statutory and voluntary agencies. But within this system an important place would be given to new emergency treatment units, which would be called detoxification centres. A man who was publicly drunk would still be charged and picked up by the police, but he would be taken to such a centre rather than to the police cell, and the charge would usually later be dropped. At this centre an inebriate could initially be held for 72 hours, but on the signature of two doctors a further seven-day order could be made. The centre's job would be not only the immediate one of detoxification and physical care, but would also include full assessment of social needs and the planning of aftercare, in which specialized alcoholism hostels would play a major part.

That society should today be taking the problem of the habitual drunkenness offender seriously results from the coincidence of several very different factors. Firstly, there has been the need to relieve overcrowding in prisons and the strain on the courts. In 1968 there were 2,719 receptions of men and 206 receptions of women into prison for drunkenness offences,[2] while at any one time between 100 and 200 prison places were occupied by such cases. On an average day the police and the courts deal with more than 200 public drunkenness offences. Another stimulus for change has been the growing body of research which has followed on from the pioneering work of M. M. Glatt and J. S. Whiteley[3] and of D. Parr,[4] which has shown that the typical drunkenness offender—far from conforming to the popular stereotype of the happy roisterer—is most usually someone heavily addicted to alcohol[5] and deserving of the label "alcoholic." Research has also shown the extreme degree to which these people are socially isolated; they are usually without jobs, homes, or close human contacts. An experimental skid row hostel in London[6] has proved that rehabilitation is a real alternative to repeated gaol sentences, while successful experiments with detoxification centres in Eastern Europe and the U.S.A. must also have been a spur to change. In America the contention that the drunk is ill rather than deserving of punishment was fought all the way up to the Supreme Court, and then the case was lost only because no real alternative to imprisonment seemed to hand. Avoiding the American dilemma, the Criminal Justice Act of 1967 invited new thinking on drunkenness by an enabling clause (Section 91) which would substitute alternatives to imprisonment for drunk and disorderly when (and only when) the Home Secretary of the day was satisfied that alternative facilities really existed. An important international conference held in London in 1968 brought many matters into focus,[7] and the personal commitment of a reforming Under Secretary of State—Lord Stonham—set the working party on its task.

Given the report, how are any of its ideas to be realized? The last major review of the country's drunkenness problem was undertaken in 1834, and that Select Committee recommended among other measures the abolition of the Navy's rum ration: the recommendation was followed in 1970. We should heed that cautionary tale. The present working party's report is in fact weak when it comes to the practicalities of action, and seems rather piously to hope that vastly complex organisational problems need be matched by no very special or imaginative efforts. Nevertheless, "co-ordination" must become more than a hopeful slogan. The Department of Health is presumably going to share some partnership with the Home Office, despite the working party's restricted terms of reference, which supposedly limited its attention to "treatment within the penal system," and a host of voluntary organizations with strong traditions of individuality are also going to have to be brought into the scheme. Moreover, even then much more than the right committee structure will be needed: people with conviction and energy and mobile teams willing to travel. The demand is for expansion of specialized hostel places from 92 at the end of 1969 to an eventual 5,000, and of detoxification beds from zero to something over 500. The way ahead will not be easy.

[1] *Habitual Drunken Offenders*. London, H.M.S.O., 1971 (see *B.M.J.*, 1971, **1**, 617)
[2] Home Office, *Report of the Work of the Prison Department*. Statistical Tables for 1968. (Cmnd. 4266), London, H.M.S.O., 1970.
[3] Glatt, M. M., and Whiteley, J. S., *Monatsschrift für Psychiatrie und Neurologie*, 1956, **132**, 1.
[4] Parr, D., *British Journal of Criminology*, 1962, **2**, 272.
[5] Gath, D., Hensman, C., Hawker, A., Kelly, M., and Edwards, G., *British Medical Journal*, 1968, **4**, 808.
[6] Cook, T., Morgan, H. G., and Pollak, B., *British Medical Journal*, 1968, **1**, 240.
[7] *Proceedings of an International Symposium on the Drunkenness Offence*, ed. T. Cook, D. Gath, and C. Hensman. London, Pergamon, 1969.

Antibacterial Agents in Renal Failure

A patient with poor renal function faces two risks when he has to be treated with a drug which is mainly excreted by the kidney. Firstly, there is the danger of toxicity resulting from a high blood concentration secondary to the impaired excretion; and, secondly, there is the equally important risk of his being denied necessary treatment because of the fear of this consequence. Certainly, it is wise to avoid all but essential drugs in these patients, but none need be denied them provided that the dose is appropriately modified.

The principles of drug dosage in renal failure have been discussed by C. M. Kunin and M. Finland.[1] If a drug is stable in plasma and eliminated from the body entirely by